Perth Amboy Board of Education

ADMINISTRATION HEADQUARTERS BUILDING
178 Barracks Street
Perth Amboy, New Jersey 08861
Tel: (732) 376-6200 Fax: (732) 638-1004

Derek J. Jess
School Business Administrator/
Board Secretary

HEALTH BENEFITS COVERAGE: 2020-2021 SCHOOL YEAR

Your health insurance coverage will begin on the first day of your contractual employment. Employees are eligible for Medical *(Aetna)*, Prescription (*Benecard*), Dental (*Delta Dental*) and Vision (*VSP*) coverage. All enrollment forms must be submitted within thirty-one (31) days of your contractual start date.

NJEHP MED AND RX CONTRIBUTION

Base Salary	Single	Family
Less than $20,000	1.7%	3.3%
$20,001 - $30,000	1.7%	3.3%
$30,001 - $40.000	1.7%	3.3%
$40,001 - $50,000	1.9%	3.9%
$50,001 - $60,000	2.2%	4.4%
$60,001 - $70,000	2.5%	5.0%
$70,001 - $80,000	2.8%	5.5%
$80,001 - $90,000	3.0%	6.0%
$90,001 - $100,000	3.3%	6.6%
More than $101,000	3.6%	7.2%

DENTAL AND VISION CONTRIBUTION

Base Salary	Single	Family
Less than $20,000	1.5%	1.5%
$20,000 - $29,999	2.3%	3.5%
$30,000 - $39.999	2.9%	4.0%
$40,000 - $49,999	2.6%	4.3%
$50,000 - $59,999	3.7%	6.4%
$60,000 - $69,999	4.2%	7.9%
$70,000 - $79,999	4.3%	8.9%
$80,000 - $89,999	3.9%	8.4%
$90,000 - $99,999	3.7%	8.6%
More than $100,000	3.7%	8.6%

To estimate your required contribution for medical and prescription benefits, (1) multiply your base salary by the percentage corresponding to your salary threshold; that is your yearly contribution. (2) divide your yearly contribution by 20 (10 month employee) or 24 (12 month employee) to calculate your per paycheck cost.

$_____ x _____ = $_____ ÷ _____ = $_____

Your Annual Salary | % Contribution | Yearly Cost | 20 or 24 | Per Paycheck Cost

To estimate your required contribution for dental and vision benefits, (1) multiply the premium (below) by the percentage corresponding to your salary threshold under the "Dental and Vision Contribution" chart; that is your yearly contribution. (2) divide your yearly contribution by 20 (10 month employee) or 24 (12 month employee) to calculate your per paycheck cost.

Dental and Vision Premium
Single: $546 or Family: $1,578

$_____ x _____ = $_____ ÷ _____ = $_____

Single or Family Premium | % Contribution | Yearly Cost | 20 or 24 | Per Paycheck Cost

Please indicate the coverage you wish to receive:

☐ **Single Coverage** ☐ **Family Coverage**

_____ _____ _____

Date | Employee's Signature | Print Name